Minnesota Department of **Human Services**

DHS-6069B-ENG 6-10

Mental Health Targeted Case Management

Child/Adolescent Diagnostic Verification Form

This form is meant to facilitate the eligibility determination process for mental health targeted case management services. It can be sent by a mental health targeted case manager to a mental health professional for the purpose of verifying that a client meets criteria for Severe Emotional Disturbance (SED).

CLIENT NAME		DATE OF BIRTH		PMI #
PARENT OR GUARDIAN NAME				
CLIENT ADDRESS	CITY		STATE	ZIP CODE
TCM PROVIDER AND AGENCY				FAX NUMBER
SENT TO				DATE SENT
Diagnoses (Please complete all 5 Axes)				DATE MOST RECENT DIAGNOSTIC ASSESSMENT COMPLETED
AXIS I				
AXIS II				
AXIS III				
AXIS IV				
AXIS V				

Check and complete all that apply:

☐ Is severely emotionally disturbed as defined under the Children's Mental Health Act and Rule 79 and meets the criteria for case management services as indicated below:

- ☐ A. The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance, or:
- ☐ B. The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact, or:
- ☐ C. The child has one of the following as determined by a mental health professional:
  - ☐ 1. Psychosis or a clinical depression;
  - ☐ 2. Risk of harming self or others as a result of an emotional disturbance;
  - ☐ 3. Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

☐ D. The child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Residential Treatment

Is this client currently receiving care in a residential treatment facility or program? ☐ No ☐ Yes – fill out below

NAME OF FACILITY	DATE OF ADMISSION

Has this client previously received care in a residential treatment facility or program? ☐ No ☐ Yes – fill out below

NAME OF FACILITY/PROGRAM	DATE OF ADMISSION	DATE OF DISCHARGE

Recommendations for Initial Goals/other services including those issues identified for the client's parents or guardians:

- ☐ Mental health symptoms
- ☐ Use of drugs/alcohol
- ☐ Social functioning
- ☐ Self-care/independent living capacity
- ☐ Medication concerns
- ☐ Obtain/maintain financial assistance
- ☐ Using transportation
- ☐ Mental health service needs
- ☐ Educational functioning
- ☐ Interpersonal functioning
- ☐ Physical health
- ☐ Dental health
- ☐ Obtain/maintain housing
- ☐ Other: _____

Note: This form is not intended to be a substitute for a comprehensive diagnostic assessment completed by a mental health professional. According to Minnesota Statute 245.4876 Subd.2, providers of outpatient and day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. The expectation of the Department of Human Services is that a full diagnostic assessment will be sent to the mental health targeted case management provider no later than 30 days after a diagnostic assessment is requested.

SIGNATURE OF MENTAL HEALTH PROFESSIONAL	DATE
PRINTED NAME OF MENTAL HEALTH PROFESSIONAL	PHONE NUMBER

QUALIFICATIONS OF MENTAL HEALTH PROFESSIONAL

☐ LP ☐ LMFT ☐ LICSW ☐ LPCC ☐ CNS-MH ☐ Psychiatric NP ☐ Psychiatrist ☐ LPP